CONTINUING MEDICAL EDUCATION AND GERIATRICS*

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DOCTORS continue to learn. That is evident from the improved medical services currently provided by individual physicians in spite of the dramatic increase in required medical knowledge. What is elusive, however, is by what mechanism this acquisition of knowledge takes place.

At the turn of the century the pool of medical information was modest, and successful interventions, both prophylactic and therapeutic, limited. It has been said that, somewhere between 1910 and 1912, a random patient, with a random disease, consulting a doctor chosen at random had, for the first time in the history of mankind, a better than 50-50 chance of profiting from the encounter.[1]

In 1984 these odds have improved and continue to do so at a rate inconceivable in 1910. It is, in fact, this remarkable growth in the medical and social sciences, in part as applied by clinicians, that has contributed to the significant increase in longevity. This itself focused attention on the health care of our elderly population and the physician's diverse roles in its maintenance and improvement.

It is, perhaps, no coincidence that the word doctor derives from the Latin word for teacher. Essentially all medical schools offer continuing medical education programs. The American Medical Association, through its state societies, approves such offerings in community hospitals. Specialty boards, voluntary health agencies, foundations, specialty societies, and government agencies provide educational programs in every medical discipline.

In 1961 approximately 1,100 continuing medical education courses were offered by 200 organizations. Sixteen years later the number of course offerings had increased seven-fold under the aegis of more than 900 sponsors.[2] This exponential growth has reached the stage that in 1984, although the

*Presented as part of the Eleventh Symposium on Medical Education, The *Geriatric Medical Education Imperative*, held by the Committee on Medical Education of the New York Academy of Medicine, October 11, 1984.

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number of accrediting institutions has risen to over 2000,[3] no single repository any longer lists all American continuing medical education programs.

This expansion might not have been so orderly as it was had it not been for the establishment of national guidelines for quality standards, first by the American Medical Association and then by the Liaison Committee on Continuing Medical Education.[2] In addition, shared physician, public, and government concerns about the quality of patient care led several state societies to require evidence of continuing education for maintenance of society membership; some specialty boards formulated similar requirements for membership or offered voluntary recertification examinations; and a moderate number of state legislatures mandated continuing education credits for license renewal.[4]

But there is a further dimension to continuing medical education. That physicians continue to learn under a variety of circumstances and are also purchasers, directly or indirectly, of an increasing range of medically-related commercial products has not gone unnoticed by industry. Contributing to the physician's education through accredited medical organizations are: pharmaceutical, instrument and equipment companies; book, subscriber journal and "throw-away" magazine publishers; tape recorder, videocassette and television producers; computer hardware and software providers; and travel, hotel, airline, and resort organizations. Many excellent programs, including international symposia at the frontiers of the clinical sciences, are possible today largely through the support of industry. Commercial organizations, understandably, seek category I credits for programs they underwrite; this facilitates an appropriate arrangement between faculty, physician registrant and private industry whereby each stands to gain, yet the educational content remains under faculty control. It should be mentioned, in passing, that category I credit, still the merit badge or gold standard of continuing medical education, is today so easy to obtain that it no longer lures physicians to medical school courses or national meetings.

Critics might be tempted to refer to the present postgraduate education scene in the words of a Japanese television technician commenting on the televising of the initial failure encountered by a movie producer in raising a large, inflatable rubber King Kong to the top of the Empire State Building. He is reported to have said: "It is so American. It is big. It is, if I may say, crazy. And it doesn't work."

I am not convinced that the critics of continuing medical education are entitled to claim, categorically, that it doesn't work. It is true that the litera-

ture frequently intimates that physicians, following completion of their formal training, learn little from their continuing medical education, retain less, and fail to apply what they do retain at the bedside. Such observations, however, can rarely stand objective scrutiny,[5] no better, in fact, than those of the programs' defenders.

Nevertheless, as already noted, doctors do learn. A confounding phenomenon in evaluating the contribution of a single continuing medical education offering that lasts from three to five full days in any one calendar year is the "contamination" factor,[6] namely, that competing sources of information repeated incessantly during that same 12-month period also provide educational messages. These include peer contacts, consultations, conferences, hospital standards, second opinions, laboratory tests disapproved for reimbursement, medical journals, drug and equipment sales people, the mass media, and, not least of all, informed patients.

Continuing education, in short, does not occur in a vacuum; messages get repeated, filtered, and frequently what is practical is retained. Contamination in no manner, however, argues against this being, at the very least, a contributor to the physician's learning process—even if the degree of that contribution is not presently measurable. But contamination has not been adequately appreciated as one factor interfering with the evaluation of continuing medical education offerings.

The 1978 report by the National Academy of Sciences noted very few continuing medical education opportunities in the care of the elderly.[7] In 1977 *J.A.M.A.* listed, out of a total of 7,330 courses, 37 (or 0.5%) geriatric offerings.[8] In 1984 the A.M.A. listed only those courses submitted for publication in *J.A.M.A.*. That number approximated 3,100, of which 41 (slightly over 1%) were in geriatrics.[9]

Whether or not this increase is real, in excess of one quarter of a million physicians provide primary or specialty care to an increasing percentage of the American population in the older age groups concerning whom a scientific data base is in its adolescence. Moreover, the vast majority of these practitioners, particularly those 10 years beyond formal training, have never been exposed to organized geriatric education in medical school, residency or fellowship training. Leaving aside for the moment the quality of continuing medical education, the number of course offerings alone is inadequate to meet the truly pressing needs of these physicians and their patients.

Since the Institute of Medicine has reviewed the overall scene of geriatric continuing medical education and its relation to aging and medical education,[7] it may be revealing to review experience at a single institution. For

this purpose I have selected one, not because it is an ideal model, but because it is one with which I have had some personal experience.

The Post-Graduate Medical School is the component of the New York University Medical Center administratively responsible for continuing medical education. The faculty members hold dual appointments in both the School of Medicine and the Post-Graduate Medical School. The Post-Graduate School has a small, full-time staff, a Liaison Committee consisting of one or more senior faculty members from each department whose responsibilities include identifying appropriate topics and course directors for various continuing medical education programs, and a Visiting Committee of outside consultants with skills in education and communication.

Among the various units under the New York University medical umbrella is one center, now more than a decade old, developed for the care of the aged. It is a multifaceted organization with broadly-based programs of total health care for the elderly and involving a partnership, particularly with the Bellevue Hospital Center, but with all its other affiliated institutions as well. This center now has extensive responsibilities for educational, research, and clinical activities, including, for example, a roster of more than 3,000 active patients with an average age of 83. The resources of the university are available to the core faculty, who are responsible for proposing and executing continuing educational offerings. One striking characteristic of the members of this faculty that extends into the continuing education area is that they are imbued with the philosophy so enduringly expressed in the closing sentence of Francis Peabody's classic 1926 medical student lecture: "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."[10] Without that viewpoint, no clinical geriatric program could prosper, nor would its continuing medical education offerings be meaningful.

Continuing medical education activities can be divided into six categories: Two Category I-approved weekly rounds and conferences open to practicing physicians in the metropolitan area; consultations by core faculty members both within and without the institution; an annual three-day course for primary care physicians, in which different areas in geriatric medicine are updated each year; a one-on-one tutorial of one or two months duration offered to physicians desiring an in-depth exposure to geriatric medicine not possible from a short program alone; a fellowship program of two years for physicians selecting a research or clinical career in gerontology; finally, faculty members participate in geriatric continuing education programs in other institutions. Two examples can be mentioned briefly. In the first, mem-

bers of the geriatric center have collaborated with a major American corporation in developing the medical component of an overall retirement program for employees approaching retirement. The second example relates to a request from the University of Puerto Rico for our core faculty in geriatrics to assist them in developing their own geriatric programs.

The three-day course for primary care physicians has been held annually at New York University for the past five years and has two principal goals: first, to distinguish the inevitable changes of aging from medical conditions requiring therapeutic interventions; and second, to identify those medical problems that require special approaches simply because the patients are of an advanced age.

How is the material selected? Practicing physician input comes informally and from critiques submitted at the end of the course with specific and frank comments as to what was helpful, what was not, and what should be covered next time. This information is then related to the core faculty's judgments based, in large measure, on their recognition of correctable physician-deficiencies as exemplified by extensive patient referrals to the center from private practitioners. These referrals readily expose many areas of health care that can be addressed in a short program.

In the course itself, lectures form a diminishing portion of the curriculum, whereas back-up data and references are provided in the course syllabus. A large segment of time is devoted to multiple, small-group workshops during which physicians can present their own problem cases; interchanges between faculty and registrants are fruitful. In addition to allowing ample time for questions, the core faculty members attempt to be available both at coffee breaks and around the lunch hour to respond to individual questions.

Some of the obstacles to the hoped-for success encountered by such a program can be appreciated from some demographic data provided by the registrants who attended the December 1983 geriatrics course and by a summary of their critiques. Ninety-three registrants, ranging in age from 28 to 86, came from 18 states and several Canadian provinces. Fifty-nine were trained in American or Canadian schools, 10 in European institutions, and 24 in medical schools elsewhere around the world. There were 23 general practitioners, 32 family physicians of whom 24 were certified, 45 internists of whom one half were certified, and seven from other specialties. Some had hospital and/or medical school affiliations, others had neither.

From this data base alone one might anticipate a wide range in the approval rating of the program. Although the program received an overall "good" rating, concerns of the registrants are worth reiterating even though

neither new nor surprising: more pathophysiology in the course syllabus rather than in the presentations; more time on *what to do*; more practical material—more on drug doses; more case-oriented material; and more for physicians who are not at a medical center. These reactions, although specifically mentioned by only a handful of registrants, were expressed despite a major effort by the faculty to cut these criticisms off, as it were, at the pass.

In essence, facult members of a continuing education course in geriatrics or, for that matter in many courses offered to primary physicians, face unusual hurdles in that physicians who attend have, through no fault of their own, a marked variation in basic science knowledge, in clinical competence, and in motivations for matriculating. In comparison, faculty members teaching an American medical school class in a university affiliated residency or fellowship program or, as our experience demonstrates, in a continuing education course for board certified neurosurgeons or rheumatologists do not share similar obstacles to effective communication.

The message, I believe, does not equivocate. It is, perhaps, inappropriate, and certainly unrewarding, to ask the average nonspecialized clinician to retain the significance of the coagulation cascade as a basis for understanding anticoagulant drug action, but it is essential that he know how to test for hemostatic competence before his patient is subjected to surgery. Geriatric programs for primary care physicians must have realistic goals, be relevant to clinical medicine, and, above all, be practical and case-oriented, because that is how most primary care physicians learn on a daily basis. Finally, material presented must clearly delineate in specific terms how the diagnosis and management of disease in the elderly does, or does not, differ from that of the same disease in the middle aged. To do less is to invite disaster.

The Princeton philosopher, Walter Kaufmann, said it better when he wrote: "Cliches about knowledge being its own reward and about following the truth wherever it may lead ignores the crucial question of priorities. Not all knowledge is equally rewarding. Nor do we encourage students or professors to spend years pursuing the truth about the father of the secretary of the man who ran unsuccessfully for Vice-President of the United States."[11]

In closing, may I suggest that, if continuing medical education providers do accept this message, it may be realistic to anticipate that, between 1985 and 1990, a random primary care physician with a random interest in continuing medical education, attending a geriatric course chosen at random would have, for the first time in the history of medical education, a better than 50-50 chance of profiting from the encounter. Critics might argue that such expectations are excessively optimistic, whereas proponents might an-

ticipate a better yield. In either event, both sides would do well to recall an ancient Chinese proverb: "To prophesy is extremely difficult, especially with respect to the future."

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